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33 YEARS

OF PROFESSIONAL

MEDICAL MISSIONS

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the medical missionary

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The Medical Mission Sisters, founded in 1925, by Mother Anna Dengel, M.D., are a religious congregation, dedicated to the care of the sick in the missions. The Sisters staff hospitals in India, Africa, Pakistan, Indonesia and South America. American Provincialate: 8400 Pine Rd., Phila. 11, Pa.

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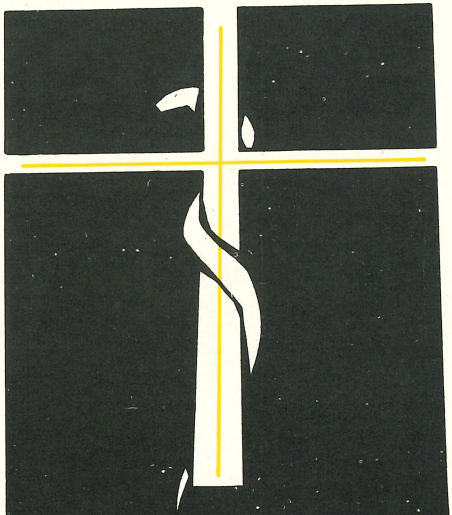
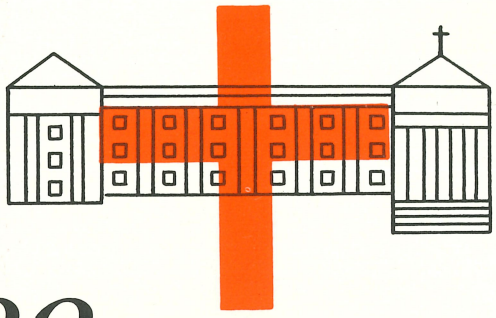
THE MEDICAL MISSION APOSTOLATE PUTS SCIENCE AND SKILL AT THE SERVICE OF THE MISSIONS



Care of the sick demands the best. Wine and oil were the Good Samaritan's best, but God has placed modern hospitals, drugs and techniques at the disposal of the Medical Mission Sister. "Today the practice of Medicine combined with the religious life can be and is a powerful instrument in the extension of the Kingdom of Christ."

—Pope Pius XII



Hospitals offer splendid opportunities for presenting the Gospel message in word and deed. They represent CHRISTIANITY in ACTION, and this is something all classes understand and appreciate.

33 YEARS OF PROFESSIONAL MEDICAL MISSIONS

1925-1958

Our century has seen the development of a new and important phase of Catholic Medical Mission Activity, THE MEDICAL MISSION APOSTOLATE. Not that care of the sick in mission lands is something new, since missionaries throughout the ages have always relieved suffering to the best of their ability. The "newness" consists in the introduction of *organized* systematic medical care of the sick by missionaries, Religious and lay, men and women, who are professionally trained as doctors, nurses, technicians, etc., thereby making their charity more effective and widespread and a powerful auxiliary in the extension of the Kingdom of Christ.

The presence of Sister-doctors in the missions today, is largely due to the far-sighted vision of Mother Anna Dengel, M.D., foundress and present Superior General of the Medical Mission Sisters, and those who helped to pave the way, notably Dr. Agnes McLaren, a Scottish convert and pioneer woman doctor. It was Dr. McLaren who introduced Mother Dengel to the idea and need of medical missions.

Thirty-three years ago in September 1925, Mother Anna Dengel, M.D. founded the Medical Mission Sisters, the first Religious Community of Sisters to dedicate themselves exclusively to the scientific care of the sick in the missions. From the founding four in 1925, the Medical Mission Sisters have grown to an international community of 600 Sisters with medical mission centers extending from India, Pakistan, Indonesia, Africa, South America to Southern United States.

Thirty-three years is a goodly span of years . . . sufficient to have one take an evaluating look at this new apostolate, which is now recognized as an integral part of the giant mission program of the Church. Looking backwards and forwards, one may ask, what are the prospects and opportunities for the next few years? And is it worthwhile.

A great impetus was given to the Medical Mission Apostolate in 1936 with the far-reaching Instruction issued by the Sacred Congregation of Propaganda Fide, allowing mission Sisters to study and practice medicine in its full scope. This Instruction, not only gave its stamp of

approval to the Medical Mission Sisters but urged other communities to take up the work, and new communities to be founded for health work in the missions.

Thus the Church's ageless duty of charity towards the suffering was put into the hands of professionally trained religious.

During the last century, whole continents in the East—the mission lands, or the underdeveloped regions of the world — where the health problems facing the people present a staggering picture of poverty, hunger and disease — have slowly awakened through contact with the West. Now, they are increasingly desirous of profiting by the scientific progress of the times, and of raising the standards of life and health in their countries. The whole world it seems is on the threshold of a new era, where a great equalization is going on, so that those who have, may share with those who have not. Communism has taken advantage of this struggle for its own ends.

In this new era the old social program of the Church, the Corporal Works of Mercy, wherein the medical mission apostolate falls, has an unprecendented appeal and greater opportunities than ever before. But these opportunities carry with them heavy responsibilities. The task is gigantic because the peoples of these areas are beginning to have ambitions to do things to better themselves; they demand the best. This points to the main role of the Catholic Mission Hospital, namely spiritual and professional leadership. While we need to aim at multiplying hospitals as much as we can, we can never hope to keep up with the need. Therefore we need to aim at leadership. "Great and tremendous efforts are necessary to obtain the wherewithal to build Catholic Hospitals in the missions and equip and staff them with fully qualified personnel. They are the *sine qua non,* not only for proper treatment in many cases, but they are schools where all who enter may and should learn the Christian way of dealing with suffering humanity. The doctors, interns, nurses, and others can and should learn to become leaders in turn, to lengthen the chain of helping hands as much and as quickly as possible. The training of nurses is of particular importance."

The Catholic Medical Mission Apostolate has made great strides in this 20th Century, but it is only beginning. In the sum total of all Catholic missions, there are a number of hospitals and dispensaries, but they are sparsely sown, and what is more, they are still sparsely staffed with fully trained personnel. In India, for example, to the honor of the Protestants we may say, that they have 300 well staffed hospitals, while Catholic hospitals scarcely number 50 . . . and some of these are very small.

What of the future? The Church has unlimited resources of Faith, which will always give motivation to the work; secondly, the unlimited generosity of our young people who follow the call to devote themselves to the wounded stranger on the roadsides of the world; and thirdly, the prayers and alms of the Faithful. They are the bank of Providence. We may be confident that in God's Providence they will be particularly abundant now when it is so evidently urgent to lead the helpless, groping, suffering millions to a God-willed standard of spiritual and moral enlightment and physical betterment which is the task of the MEDICAL MISSION APOSTOLATE.

MEDICAL MISSIONS

I went to Rawalpindi, a city in the far northwest corner of India (now Pakistan) in 1920. For four years I was in charge of a small hospital for women and children in a predominantly Moslem area. The work was very interesting especially the Out-Patient Department, which provided many types of people with a great variety of diseases, languages, religions, costumes and customs. But the visits to the homes were far more revealing of the mode of life and health conditions. As a woman-doctor, I had entree to rich and poor. In most homes the patriarchal con-joined family system prevailed so that several families at different age levels lived together. Visiting many such families over a period of time gave one a good picture of general health conditions. Usually, in addition to seeing the patient to whom I was specifically called, I was also asked to examine or look at others who were more or less chronically ill. Frequently it was TB or pelvic or intestinal trouble or skin or eye diseases, hysteria, intestinal parasites, fevers, etc. Severe anemia was common; the crippled and blind were also rather frequent. There was a staggering amount of untreated, unrelieved and preventable suffering.

A fatalistic attitude seemed the rule. What else could one expect with little or no medical aid available? The average expectancy of life was only 27 years. The maternal and infant mortality were particularly high. The literacy was very low; in the case of women, only two per cent. While I met some very rich people, the majority were poor and often miserably poor. Hospitals and doctors were few. One felt, of course, that one should do something but no matter what, it would only be a drop in the ocean of need. The special need there was for dedicated, professionally-trained women. It seemed to me that I had to broadcast what I had seen with my own eyes. Somehow, I felt confident that the interest of Catholics could be aroused and enlisted just as has been the case with Protestants earlier. At that time there were very few Catholic hospitals in the missions. In India, I only knew of one real Catholic hospital and five small

Mother Anna Dengel, M.D.

IN THE NEW ERA

Three Pioneers, Mother Anna Dengel, M.D., Sister Agnes Marie, R.N., and Rev. Michael A. Mathis, C.S.C.

ones like the 16-bed one with which I was connected. There were a number of dispensaries of course which in those days could be carried on by anybody with good will and some practical experience.

I came to America in 1924 armed with a visa for six months, never dreaming that I would stay here. Miss Pauline Willis from Boston, then residing in London, who had been interested in medical missions for some years, offered to accompany me for six weeks to introduce me, which was of a great help as I did not know anybody in America. Two things in my life I could never have dreamt of: one, that America would be the country where the organization for medical missions I was hoping for, would come about; and the other, that an evolution and revolution, such as has taken place in India since 1920, could or would be possible.

In reality of course this change was not as sudden as it appeared on the surface. A hundred years of western education could not help but produce an awakening, leading the Indians to self-assertion and a re-thinking and a re-appreciation of their own culture. As regards health matters, an important progressive step was taken during the last years of the English regime when a thorough survey of health conditions and provisions was made and published, as the Bhore Report. The recommendations were seriously begun after attaining Independence in 1947 and have made headway steadily and intelligently as evidenced by the fact that the average expectancy of life has risen from 27 to 32 years — a remarkable feat when one visualizes a mass of 366 millions to be moved; of course, they are not all moved yet. But on the whole they are eager, even impatient for progress and cooperative.

The extraordinary change in world affairs as the result of wars, bringing people in close touch, exposing the deplorable, often subhuman conditions of vast populations, changed the attitude of the more advanced countries from one of hoarding to one of giving and sharing not only of money and goods but of technical skill and per-

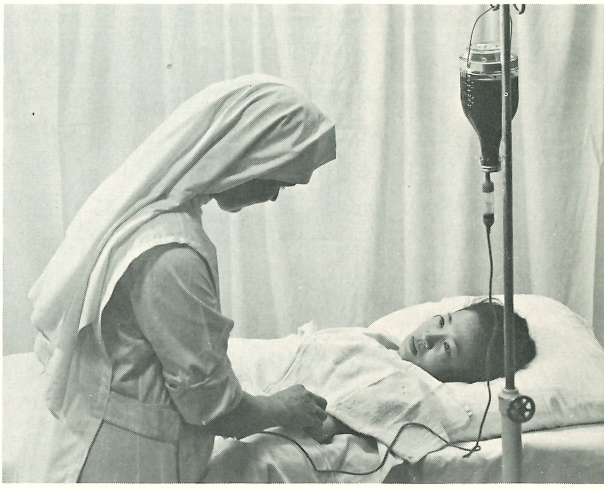
sonal service. This was previously done on a small scale, mostly by missionaries, although not so small when one considers that the Protestants alone in 1925 already had 799 men and 356 women doctors and 878 hospitals in the missions and were treating over 10 million people annually.

Catholics were hardly represented in the medical field but they did have flourishing educational institutions, even in remote parts of the world. In the medical mission field Catholics only really began to organize actively after the first World War. A group of Catholic medical students in Munich were the first to band themselves together. This was the nucleus of what became a few years later the now well-known Catholic Medical Mission Institute of Wurzburg. It is a lay organization of men and women doctors who have the most Catholic mission doctors up to now. As far as I know the Catholic Medical Mission Board in this country was next, founded in 1922 with Rt. Rev. Msg. J. McGlinchey and with Mr. Floyd Keeler —now Father Keeler—as the main leaders. Father Mathis, C.S.C., who was also a member of the Board, helped in 1925 in the foundation of our Society—the Society of Catholic Medical Missionaries. It was the first religious community of medical missionaries. About the same time movements to promote medical missions, either sending doctors or material help, came into being in France, Belgium, Holland, Ireland, Italy, practically in every country in Europe. In 1936 Propaganda Fide, at the request of Cardinal Dougherty, and many mission Bishops, issued an Instruction urging the foundation of new religious communities of women dedicated mainly to health work in the missions, allowing Sisters with public vows for the first time to study and practice medicine and obstetrics. This quickly bore fruit in the foundation of several new communities such as the Medical Missionaries of Mary in Ireland, and the Daughters of Mary, Health of the Sick, in New York; and other communities already in existence, also took up the work. Now after thirty odd years of pioneering, Catholic Medical Missions, like all medical missions, stand before a situation which is practically new and has its problems.

One problem is that gigantic allies have come on the scene in the form of powerful technical and financial contributors, such as WHO, Foreign Aid (FAO), Colombo Plan, Rockefeller, Ford and other foundations, all channeled through governments which make use of them to step up the number and quality, mainly of their own medical institutions. For mission hospitals, it means, that they must keep pace. This demands skilled personnel educated at great cost, also modern buildings, expensive equipment and medicines. The financing of all this in a country where millions do not even know where their next meal is coming from, where no social insurance of any kind is available, confronts medical missionaries with a new problem which needs deep consideration to find a workable solution. It seems at this juncture the problem is beyond individual communities and groups. A way has to be found to make it possible for works of charity in the missions, such as Catholic hospitals, to carry on under these conditions.

Up to now Catholic physicians (with few exceptions) are neither aware of the work and potentialities of medical missions, nor the problems and responsibilities connected

Mother Anna Dengel, M.D. seated at table at St. Catherine's Hospital, Rawalpindi, in 1923, before she founded the Medical Mission Sisters.

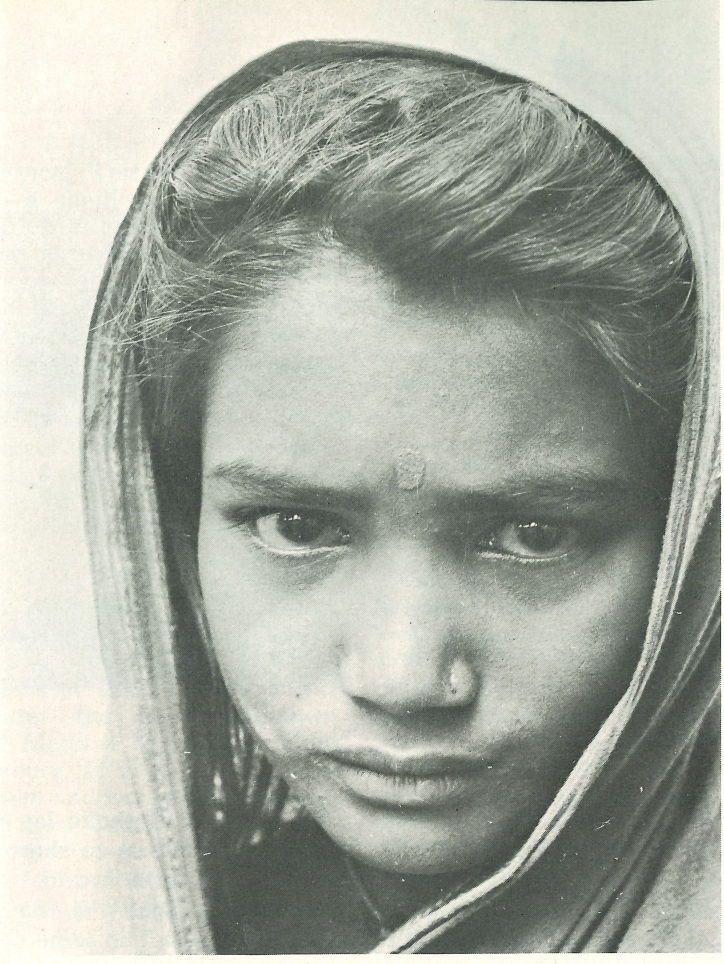


Professional men and women are needed for medical missions today. Sister Marie Joan, M.P., Dacca, E. Pakistan

with them. It seems that at this time when all doctors have heard of the deplorable health conditions in the undeveloped and under-developed countries, it should not be difficult to enlist their interest and help. The Protestants are an admirable example. Through a hundred years they have built up a practical program for lay doctors in the missions. They have well-planned facilities and arrangements for the married and the unmarried; they have special schools for children in good climates, they have a social life among themselves; they have achieved good working conditions, and salaries, furloughs and retirement are guaranteed, all of which makes the Protestant medical mission efforts so successful. The above is still more or less precarious in many Catholic medical missions which makes it hard and risky on all sides and is an obstacle to the going forth of Catholic lay doctors in greater numbers to share in the making of a better world.

Another difficulty is the present anti-mission spirit in some countries which, however, affects medical missions less than other work on account of the much-appreciated social service they render. The anti-mission feeling must be understood. It has its roots in the first fervor of nationalism which needs the strong prop of the age-old tradition of religion and culture and wants to boost its own efforts in the social field especially those produced by the purification of its own house and consequent new spirit of service. In a sense this latter is the result of western influence and to a great extent Christian influence.

The question arises: Shall one halt at this juncture when the whole Asian and African world is in a ferment, in a mood of receptivity as



perhaps never before recognizing health as a personal as well as a national asset? Shall one halt just because we are no longer the masters and are only welcome as servants, because at times we may have to suffer contempt or persecution even for doing good? Shall one halt because we have to make great efforts for personal competence and generosity?

One thing is certain, as long as there are still so many countries where the lesson of the Good Samaritan has not yet reached the minds and hearts of the people, the followers of Christ *must* exemplify the law of love by medical missions. The wounded stranger of today may also expect the potent means of the science and skill of the 20th century. Amateurs can no longer fulfill the task. The duty devolves on professional men and women, who, in turn, need the support of those who want to take part in the building up of a better world through medical missions.

"LOVE YOUR SICK, and care for them with devotion. Look after them intelligently and scientifically. Treat their ailments in the best possible way. Make efforts truly to serve. Proceeding in this natural order, you will inspire the confidence and trust which prepare the mind for higher and supernatural things . . . The people must never get the idea that conversion and Baptism are necessary to reward your devoted care, your sincere and unselfish Christian charity and zeal. Use all means at your disposal to make them experience in themselves that your religion is truly inspired by self-sacrificing love." PIUS XI

NO ALTERNATIVE

Sister M. Richard

The crowd of Hindus waiting at the well paid little attention to the elderly man who limped past. Some may have noticed his slow painful pace, the running sore on his leg and the small rag bandage that scarcely covered one-quarter of the wound. Most of the men were busy discussing the day's events; the women were busy pulling full buckets up the steep well, and it is quite likely that they never saw the man pass. But I saw him.

He walked slowly but with determination. When he reached his destination, the hospital gate, there was no hesitation. He went directly to the figure in white. Then, mustering up all his strength, the old man shouted and the tone of his voice

was that of command: "You are a Christian," he said. "You are a Christian and I am sick. You have to help me." It wasn't a request or a plea. It was a demand. "You HAVE to help me."

The old man from Masigarh village was correct. There is no alternative. If I am a Christian, I have to help. Unknowingly, he expressed in forceful terms an idea that is basic to any consideration of the purpose, the necessity, the urgency, the value of our care of the sick in the missions.

The little Hindu with the ulcer on his leg is "Everyman" — everyman in the missions who is sick. And "Everyman" in the missions who is sick has a three-fold claim on my service. It stems from my humanity, my Christianity, my adult membership in the Church.

First, the sick man and I are fellow human beings sharing an equal right to the good which is health. I have it. He does not. I must do what I can to restore his health.

Secondly, I am a Christian and if worthy of the name, I must accept the privilege and responsibility of being a follower of Christ who said that all men are my neighbor and that I must love each to the extent that He did. If I see my neighbor in need, there is no alternative, I am compelled to help. The greater his need; the greater is my obligation to help.

In the third place, I am a confirmed member of the Church, participating in the fullness of Her life. By that fact, I share in the mission of the Church, the need She has to reach out to all men, to be a witness to the love of Christ. I am obliged to labor at the task of helping to establish the Church in all places where She is not, so that all men may come to complete Christ's Mystical Body. My neighbor does not know Christ. I must try to introduce Christ to him by letting my service be a tangible expression of Christ's love, a proof.

"I am sick." "You Have to help me." This call of the sick for assistance and the response given by Christ and His followers echoes through the pages of the Gospel. It is a hallmark down through the ages of Christianity. The compelling need for the act of charity is ever the same; the necessity of love to give, and give the best remains. It is always: "Cure me." But the response of the Church differs with the times because the concept of what is the best care of the sick changes. What was the best a missionary could give the sick who flocked to him fifty years ago is inferior care today.

Sensitive to progress, the Church recognized the necessity of providing more adequately for the sick. Her "new" way of discharging the never changing obligation of rendering service to her neighbor who suffers, is the medical mission apostolate. By this, we mean the giving of professional medical care by properly qualified persons who have the knowledge and skill to use the advances of modern medicine for the benefit of the sick. This "new" apostolate also added an emphasis to the care of the sick in the missions that was not clearly discerned before.

While it is true that Christians have always rendered service to the sick as an act of charity, they have not always regarded this care as having a direct connection with the Church's missionary effort. It was generally believed that the immediate purpose of missions was to

baptize souls. And if this were so then the care of the sick could hardly have much "missionary importance".

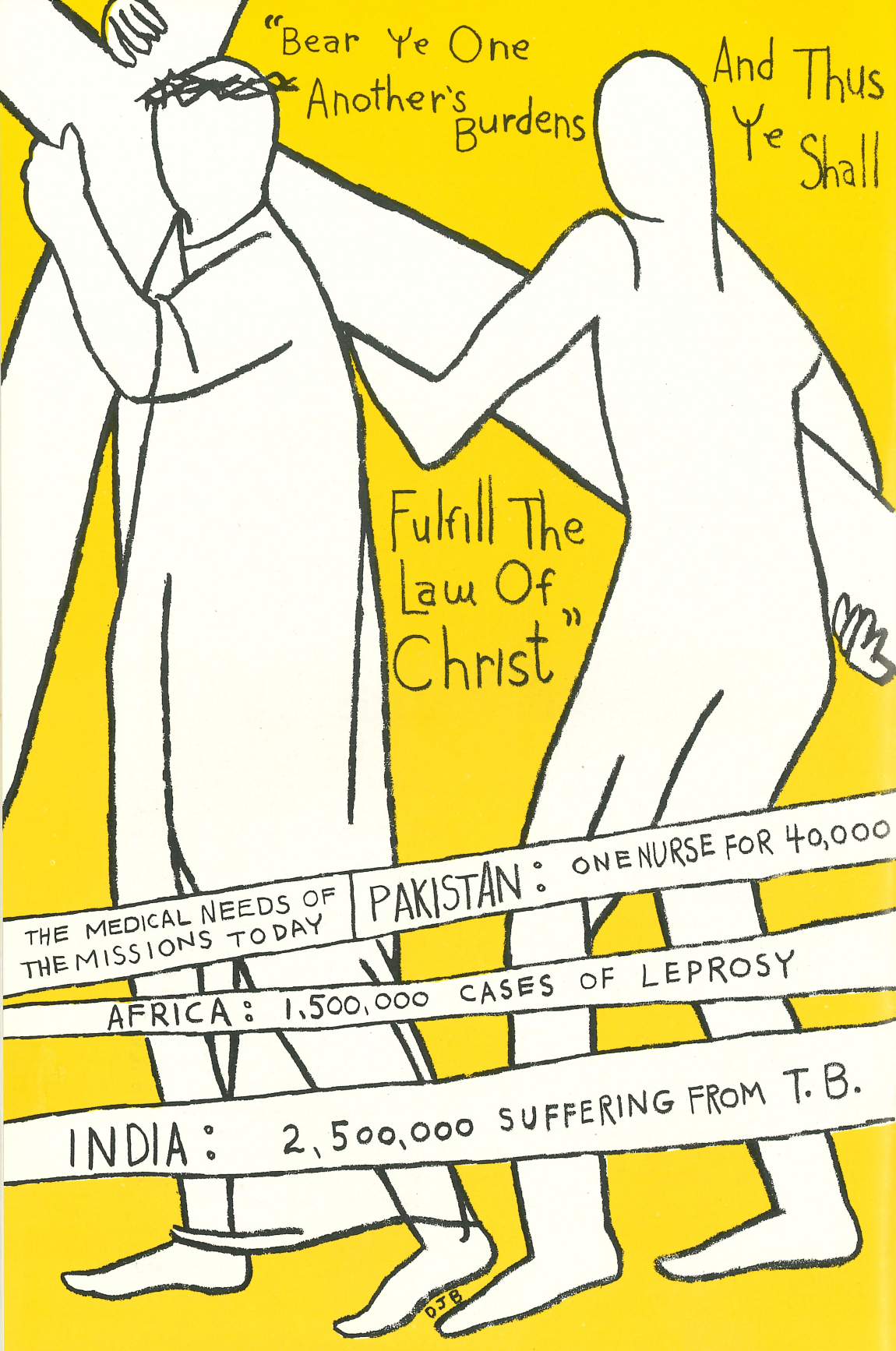
However, if you believe that the purpose of missions is to make Christ present, to establish His Church among all nations, then the value of the care of the sick assumes great importance. How tangible is Christ's love when it tends the sick. How attractive is Christian goodness to non-Christians when it is experienced so personally. Furthermore if a man is sick, he is not disposed to think of his soul's salvation. He is preoccupied with his bodily pain. And if a nation is so unhealthy that it dies, it cannot people the Church. Medical welfare is then seen as an absolute requisite for the establishment and growth of

Indian patient suffering from cholera

the Church and the Medical Mission Apostolate assumes its true significance.

Today, when millions continue to suffer, when two-thirds of the world are without proper health, when men in the missions still shout: "Cure me," there is no question but that the medical mission apostolate must be carried on and developed still more. Today, when medical science has reached such a peak that all the world wishes to taste the fruits of scientific research, then there is no doubt as to whether the care of the sick should be professional or not. Love is never satisfied with half-measure. There is no choice. It must be the best care for my neighbor and the best care today is professional medical care, a team of health workers, hospitals, training centers.

To do otherwise, to give less, is a lack of understanding of the problem, of the means at our disposal to solve it, or a lack of comprehension of what Christian charity demands of us. Only an organized effort to give professional medical care to the sick in the underdeveloped areas of the world is capable of giving an adequate answer, from the Christian, the Missionary and the medical point of view, to the call of "Everyman" in the missions. . . . "You are a Christian. I am sick. You HAVE to help me."


"Bear Ye One Another's Burdens
And Thus Ye Shall
Fulfill The Law Of Christ"
THE MEDICAL NEEDS OF THE MISSIONS TODAY
PAKISTAN: ONE NURSE FOR 40,000
AFRICA: 1,500,000 CASES OF LEPROSY
INDIA: 2,500,000 SUFFERING FROM T.B.
DJB

Sister M. Frederic, M.D. and patient, Holy Family Hospital, Mandar, India

"HE WHO SEES HIS BROTHER IN NEED . . .

Sr. M. Frederic, M.D.

We do a great deal of surgery in Mandar. But yesterday we had the best vocal anesthesia ever given in an operating room. It was a running commentary in Hindi that kept a bad risk, ten-year-old laughing till his sides would split. Of course, I missed the jokes. I was working with a medical student over the insertion of a chest tube under local, plus vocal.

Our real "anesthetist" was a young priest, himself convalescing from TB, whom we invited in to give moral support to his former altar boy. Honestly this isn't as strange as it sounds. Earlier in the morning, Joseph had, as a special concession, served Father's Mass in the hospital, as he had many months earlier when he (the boy the first to be sick) had first developed a cough. A few hours later, Father was the "server", sweating it out with us. But, Joseph's empyema is draining nicely and his lung expanding on schedule. Joseph comes from a one room city slum home, where he lived with his father, mother and two brothers until his mother died of TB last year. His family, along with those in the lowland "village" almost within the town, have no fields. In the interval between the old and new rice crops

Ouraon tribal boy, Mandar, India. Joseph belonged to this tribe.

they can only tighten their belts and grin and bear it. . . .

When Joseph came here, he was skin and bones, pale under his tan, but with a catching million dollar smile. He had a "catching" disease too — a ghastly wet cough, and an x-ray equally discouraging — one lung full of "spots", the other completely collapsed, with air and fluid in the chest cavity. About the only thing that could make him smile that day was the promise of a bed next to his big brother in the men's TB ward. Today, he smiles because he is on the road to real recovery.

Joseph and his parish priest are only 2 among the reported 2½ million people of India suffering from TB. The slums of Calcutta and the villages of Chotanagpur harbor many more that never reach the statisticians! TB is the real killer and maimer here. Only half as many people have the more dreaded but less contagious leprosy, caused by a bacteriologically related organism. Both these diseases are high on the Government of India financial allotment for health under the second Five Year Plan — hospitals, clinics and outpatient care for both are being slowly made available. Yet in the whole country in 1957, Government statistics show only 17,000 TB beds available.

In Mandar, we have 20 official ward beds for sputum positive TB men and women — a high percent for a general hospital, but a mere drop in the bucket for the whole of India. TB of all types ranks fourth among the disease treated in our hospital and out-patient department, surpassed only by anemia, malnutrition and respiratory infections other than TB. Right now, as often, the bulk of our medical service is pulmonary.

The pitfalls of statistics are many. In a land of villages, many extremely remote, they may be inacurate, but they show a trend, and the trend here is encouraging. Since Independence and concomitant with the real opening of the anti-biotic era, the average life expectancy has risen from 27 to 32 years, and the

infant mortality rate fallen from 146 to 113 per 1000. This is real progress, for any country.

In the present Five Year Plan prevention and control measures are being worked out, as well, for malaria (8th on our list of medical diseases), filaria (very low on our list), and VD (5th in our series).

How much better than statistics, if I could take my camera and show you the patient unconscious with cerebral malaria, his anxious relatives hovering about, waiting for the magic return to health. Or the worried look of the young college boy with his first bout of filaria. Or the wasting appearance of the young-old woman with inoperable pelvic cancer or the 25-year old press worker with the side of his face gone from cancer, praying God to take him, while in another room a young priest is dying of the same. Would that in the nursery, I could do a Kodachrome series of the return of a youngster with kwashiorkor, strong and healthy to the arms of his mother.

Customs, poverty and ignorance are the roadblocks to be overcome, here as elsewhere. But it is not impossible. In our sick nursery it has finally become routine to give the children an egg daily but it took two years or more to convince the mothers. Now almost the first thing they ask on admission is whether they should bring eggs. Just as now, some ask whether they need to give blood for their children. Three years ago it was a fight to the finish just to do the type and cross-match! A living demonstration literally rockets the education process ahead.

These are the things that breathe like into statistics, and tell you the story of the medical needs of a country, that tell you why there are Government of India budgets for nutrition, research, and water supply and sanitation improvement. And why we as private non-aided institutions contribute our services.

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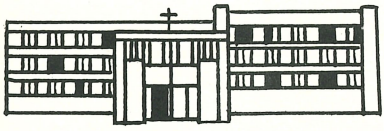
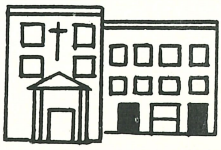
SCOPE OF THE WORK

Hospitals

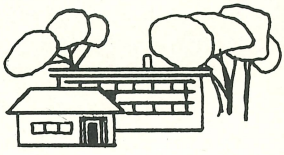


and

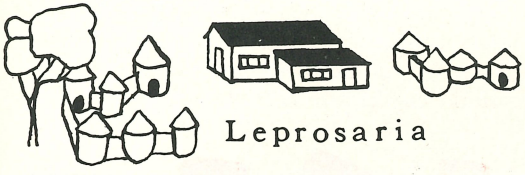
Dispensaries



Clinics

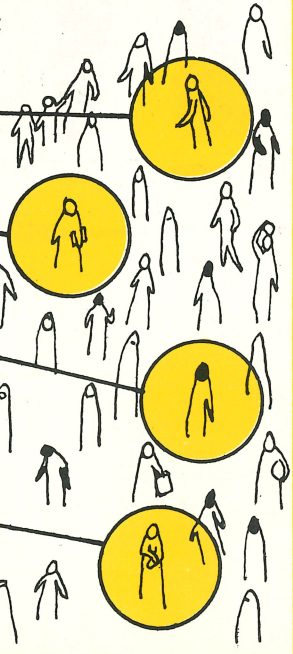


Maternity and Child Welfare Centers



Leprosaria

Training Indigenous Peoples In:

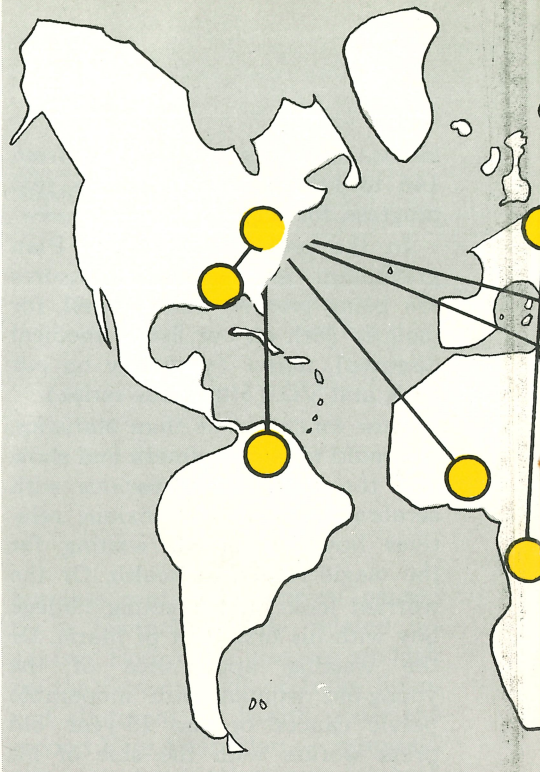


Nursing

Pharmacy

Technology

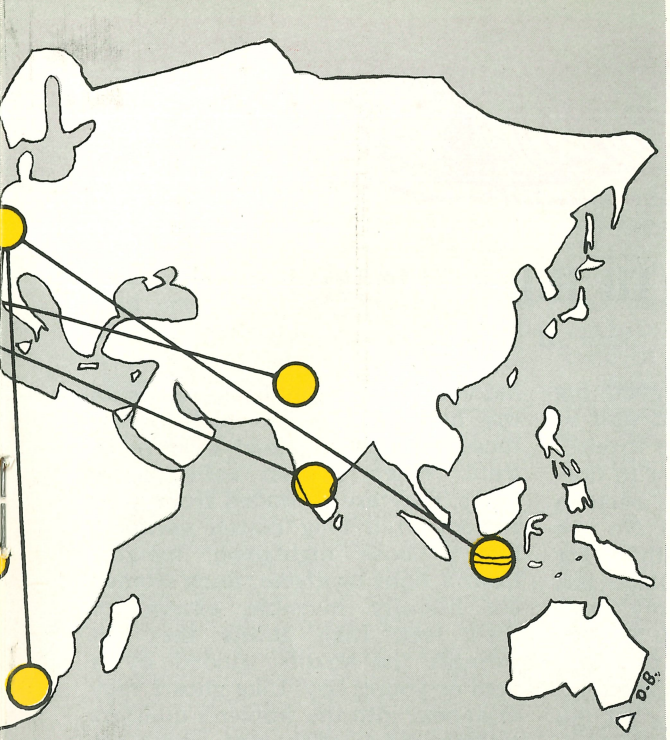
Intern Programs For Young Doctors



MEDICAL M

in:

India
Pakistan
Africa
South America
United States
Indonesia



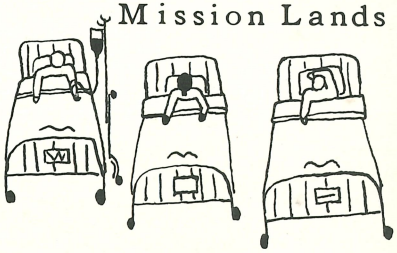
SSION SISTERS

as:

Doctors
Nurses
Pharmacists
Technicians
Secretaries
Accountants

AIMS

1 To Care For The Sick And Suffering In Mission Lands



2 To Care For Sick

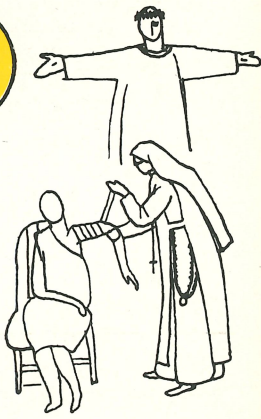
Priest

Brother

Sister

Missionaries

3 As A Witness To The Compassion Of CHRIST



GO TO HOLY FAMILY

Sister M. Elise, M.D.

"Bibi Jan, you've got a great big tumor inside. Why did you wait so long before coming to have it out?"

"Doctor Sahiba, I've been to doctors all over the place. I've been in two different hospitals also. No one has been able to do anything for me. Everybody in my village has been telling me: "Go to Holy Family. They will fix you up". So I've come 120 miles, just for this purpose. Please do the operation soon".

I wish I had a dollar for all the times I've been through the above routine. Bibi Jan, and hundreds like her, throng our out-patient department, day after day. They come from Rawalpindi and surroundings, from villages far away, from hill stations, from the Northern frontier. They have usually already tried everything they knew. They have consulted dais (untrained midwives), hakims (native doctors), village dispensaries and city doctors. But when their complaints are surgical, none of these can help the poor women. Even the village and small town hospitals are not able to do major surgery. They have only a skeleton staff, no trained nurses, no operating room equipment, none of all the ancillary services required for modern surgery. So the Bibi Jans of Pakistan often hunt around for months and years, before they find a place that can both diagnose and cure them.

On top of this, there is the problem of "purdah". Muslim women in this country ordinarily do not show themselves in public. They live a hidden life, in the back rooms of the house, where no men except those of the household ever penetrate. When purdah ladies leave home, they are shrouded from head to foot in a long cotton garment, like a loose nightgown, hanging from a tight headgear. Such women are literally invisible, except for their feet. Like ghosts they flit through the streets, guided by a man or young boy. Like ghosts they disappear into the women's quarters of their relatives' homes, which are the only places they can visit. For them there is no window shopping, no getting together in lunchrooms, no walks in the country. Men visitors to their homes are entertained by the men of the household only. What then happens when illness strikes? The same rules of conduct still hold. I have actually assisted at an examination of a lady patient by a man doctor. The two were separated by a curtain, stretched along the bedside. I had to guide the doctor's stethoscope to the patient's chest, and tell him the various findings on inspection. Internal examinations are done by women doctors, or not at all.

This type of medical care may work well enough for a sore throat or an attack of malaria, but it won't do when an operation is needed. Then these women will travel up and down the Province, in shaking, rattling, steaming buses, trying to find a woman surgeon, and a properly equipped hospital. Doctors *alone* are about as helpless as newborn babies, and much less orna-

mental. So when Bibi Jan tells us that she has come from a distance of 100 miles, she is not exaggerating. For the poor and the middle class women, the only place that can operate on them, between Peshawar and Lahore (a stretch of 200 miles), is Holy Family Hospital, Rawalpindi.

This is the great medical need of the country: fully staffed and equipped hospitals. It is the hardest of all achievements in medical care, except for the medical schools. Since Partition, eleven years ago, Pakistan has spent a great deal of energy and funds on the education of doctors and nurses. Many young men and women have been sent overseas, for special studies. But of these, the cream of the crop, over 300 have been lost to the country. Some simply never came back. Others tried to do the work they had been trained for, but because of the lack of personnel, the small hospitals could not give them the service and help they needed. Such a loss is a serious one to a young and struggling country. Government officials are racking their brains, trying to find ways and means to improve the district hospitals, so that the specialties can be practiced there. But the nurses and other personnel needed for a well run hospital are still missing. Few Pakistani women are willing to work outside their own homes. Take all the women workers out of the American hospitals, and what will be left? It would hardly be a going concern after that!

Here is where the mission hospitals can do their share in improving the status of medical care in Pakistan. Our Sister-doctors operate on the women, who are delighted to find a woman surgeon. Our Sister-nurses train the Pakistani girls to be good nurses. Better class families will entrust their daughters to the Sisters, when they would not even consider sending the girls to city hospitals. The mission hospitals, run by women entirely, show the public that such a thing is possible. Thus with each succeeding group of nurses graduating from their four year course, the future brightens. Some of these will be able to manage hospitals and wards and operating rooms. There is still a long way to go, but at least a start has been made. The Sisters who staff our hospitals in Pakistan are each of them in a key position. On their charity, patience, ability and kindness much depends. This is indeed Christianity in action .

R.I.P. *Please pray for our benefactors recently deceased:*

Rev. David P. McAstocker, S.J.,
Monrovia, Calif.

Rev. Mother Gertrude Mary, R.S.M.,
Merion, Pa.

Sister M. Judith Boer, Social Mission Sister of
Budapest, Hungary, in New York

Mr. Fred Frischmann
Ridgewood, N. Y.

Mrs. Joseph P. Hogan
East Lansdowne, Pa.

Mrs. Mary Neumann
Floral Park, N. Y.

Mr. Frank Rowan
Manayunk, Pa.

Mrs. Mary M. Rieger
St. Albans, N. Y.

Miss Elizabeth Schmidlin
Queens Village, N. Y.

Miss Mary Hartnett
Jamaica Plain, Mass.

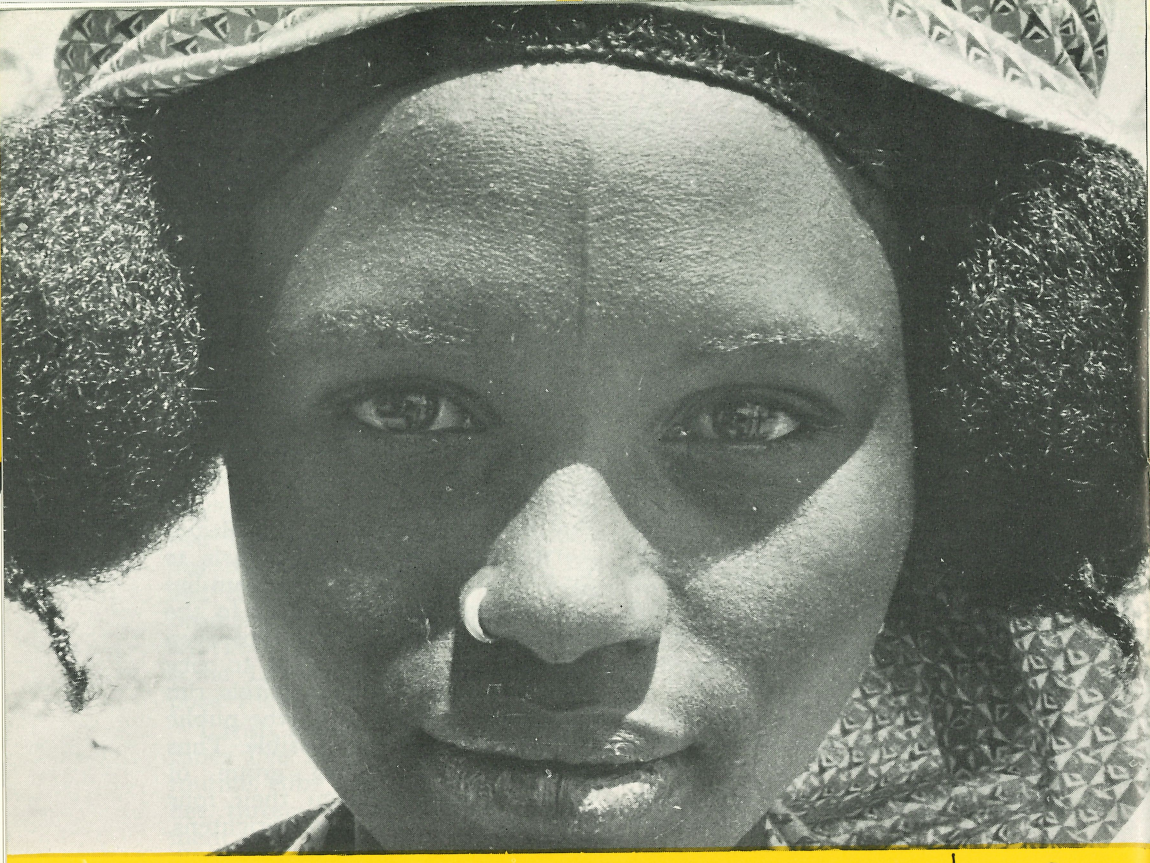
Mrs. Virginia Maunz
Fairmont, W. Va.

Mr. Andrew Grey
Upper Darby, Pa.

Mrs. Marie Melchers
Forest Hill, Calif.

Mr. Edward Murphy
Brooklyn, N. Y.

Mr. Frank Hurley (Father of Sister M. Ruth,
S.C.M.M.) Southington, Conn.



ATTEBUBU LEPROSY TREK

Sister M. Daniel

Sister M. Francis, M.D. begins her trek at Attebubu village in Ghana, north of Kokofu Leprosarium.

There are about 45,000 known cases of leprosy in Ghana, West Africa.

Sr. M. Francis, M.D. and Sr. M. Gregory, M.D. testing a spot for leprosy.

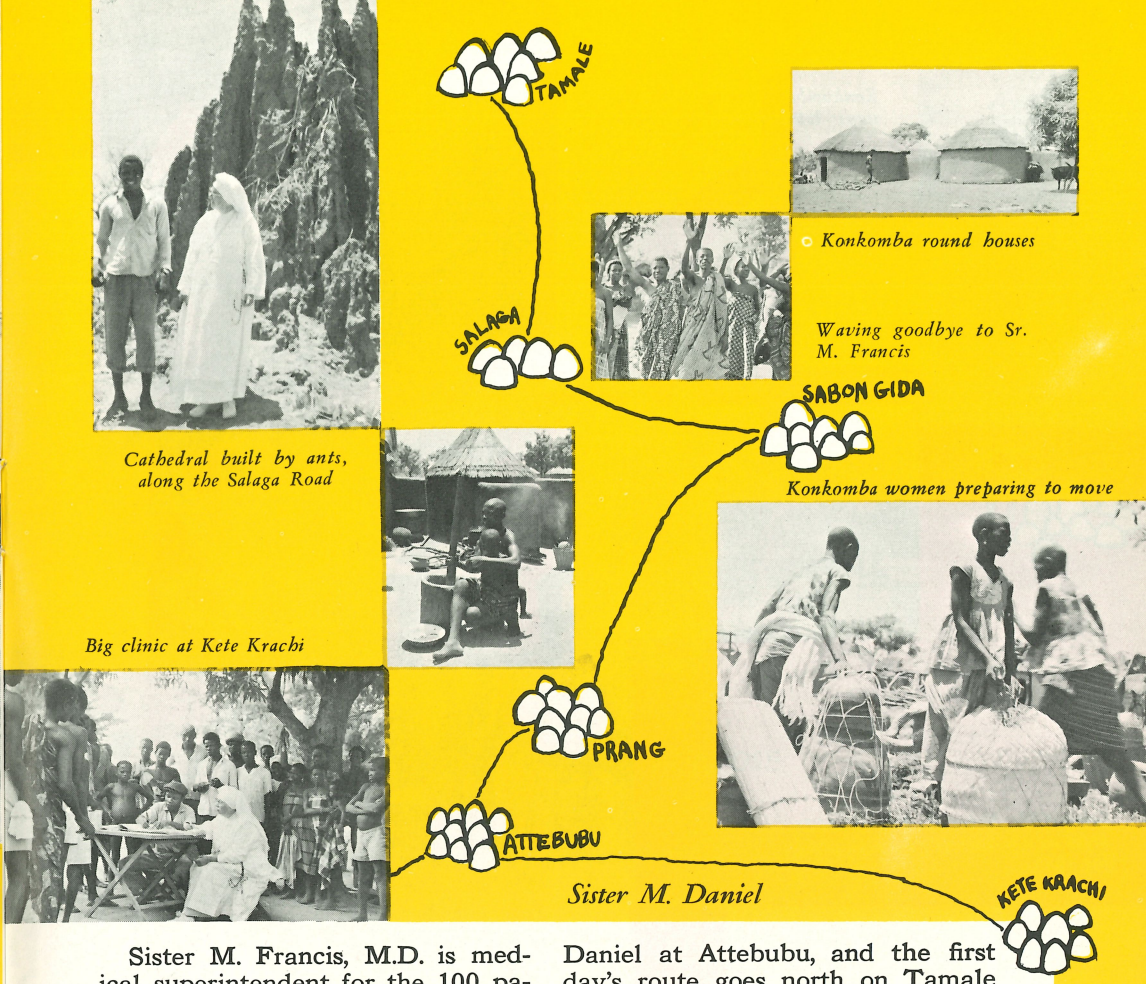
Cathedral built by ants, along the Salaga Road

Konkomba round houses

Waving goodbye to Sr. M. Francis

Big clinic at Kete Krachi

Konkomba women preparing to move



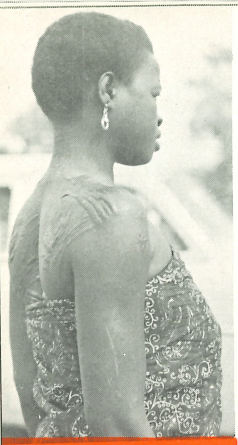
Sister M. Daniel

Sister M. Francis, M.D. is medical superintendent for the 100 patients at the Kokofu Leprosarium in Ghana, West Africa. Only those who have the lepromatous type of Hansen's Disease are admitted to the colony. The other types are treated in clinics scattered throughout the country. Sister M. Francis has 65 of these clinics under her care.

She is assisted in this work by a member of the Ghana Leprosy Service. This assistant follows a route of villages each week and gives the patients one dose D.D.S. to take immediately and one more dose for another day in the week. Periodically Sister M. Francis must visit the clinics for diagnosis, treatment and admittance to Kokofu, if necessary.

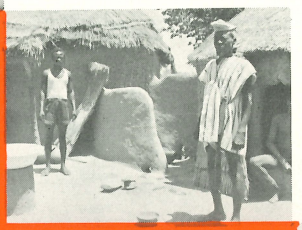
The first week's work of this trek begins for Sr. M. Francis and Sr. M. Daniel at Attebubu, and the first day's route goes north on Tamale Road as far as Salaga area in North Ghana. Each area she visits has its own style of homes, customs and language. East of Salaga Sister M. Francis meets the people from the Konkomba tribe. Sister M. Francis' greatest joy is to be able to discharge a patient after successful treatment.

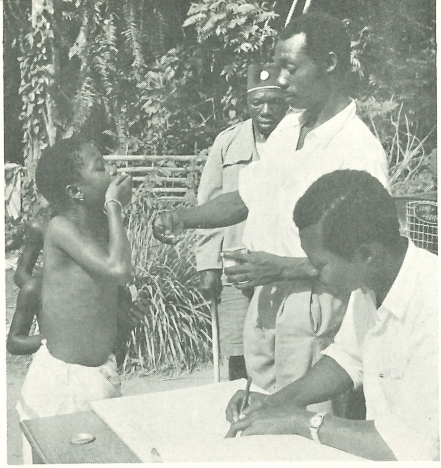
On the trek Sister M. Francis finds the Gospel stories repeated. One lady, when asked where a missing patient was replied: "Off to take care of his farm". In another village a man was away at a funeral of a relative. Another man said: "I possess a wife and five children, therefore I cannot come to the Leprosarium to be cured." He has the infectious type of Hansen's Disease.



Konkomba woman with designs tatooed on her back.

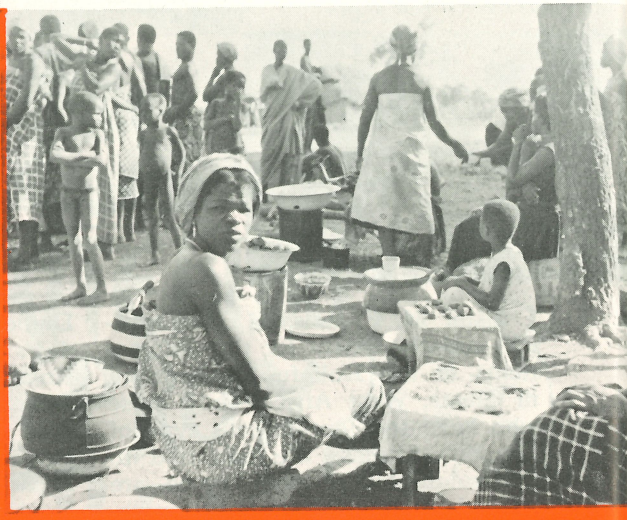
Man to right has a knife, sheathed in goatskin — he uses it to go hunting antelopes.



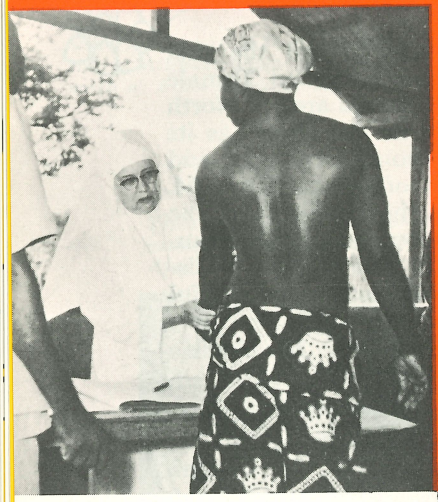


Clinic patient must take one dose of D.D.S. at the clinic. Leprosy assistant gives it to him.

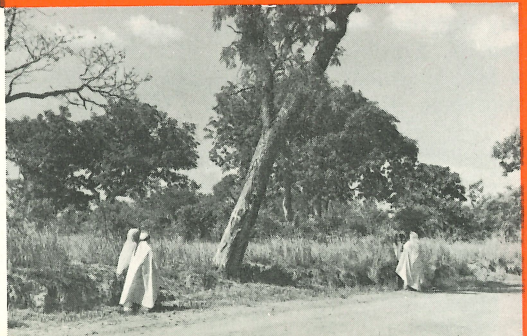
Clinic in the market place.



Sabon-Gida. Sister M. Francis, M.D. must see the patient's back to check for spots.



Arbunalaku — a completely Moslem village. Women in Burkhas come to the clinic. They really keep purdah.



MEDICAL MISSION SISTERS

HAVE A THREEFOLD UNIFIED PURPOSE

THEIR NAME CONTAINS IT ALL:

RELIGIOUS

MISSIONARY

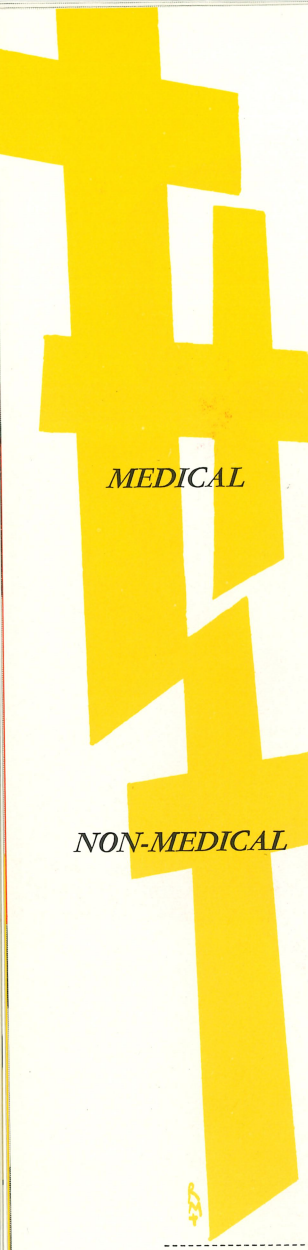
MEDICAL

RELIGIOUS

Medical Mission Sisters are above all else Sisters—religious. And because they are religious their purpose is to promote the honor and glory of God by their sanctification through the fulfillment of the three vows of obedience, chastity and poverty.

MISSIONARY

Medical Mission Sisters are missionaries. The task of the missions is to plant the Church in all countries where it has not yet been established with a view to saving and sanctifying souls. Planting the Church means to make available to the people its priesthood and hierarchy, its works of instruction and mercy, its liturgy and its forms of religious life, and its organized laity. The specific task of the Medical Mission Sisters in this scheme lies within the field of the works of mercy, to care for the sick and suffering in mission lands and as religious, to exemplify the perfect Christian life.



As missionaries, the Medical Mission Sisters must endeavor to know and love the Church, to live with her in her Liturgy, and to labor and suffer for her extension. Dealing with all races and creeds, and keeping in mind the sublime dignity of man, who is created to the image and likeness of God, Medical Mission Sisters show forth by their daily practice of charity that the Church promotes the true brotherhood of man—one Father, one Redeemer, one eternal destiny for all.

MEDICAL

Medical Mission Sisters are medical missionaries. They aim in their work for the sick to help the whole man, his body, mind and soul, and to see in their patients the suffering Christ claiming their love and sympathy. Since love expresses itself in sacrifice, they strive to do whatever is necessary for the patient without counting the cost to themselves.

NON-MEDICAL

As the medical field demands the collaboration of the different professions—doctors, pharmacists, nurses, technicians, etc. — so also a variety of non-medical activties such as writing, typing, bookkeeping, cooking, etc. are necessarily connected with the carrying on of the work of the Society. Each Sister contributes her share to the perfection of the whole; each Sister is a Medical Missionary.

Medical Mission Sisters are women with a purpose and in all things they purpose to glorify God.

MEDICAL MISSION SISTERS, PHILADELPHIA 11, PA.

Dear Sisters:

Please send me literature about becoming a Medical Mission Sister. I understand that this does not bind me in any way.

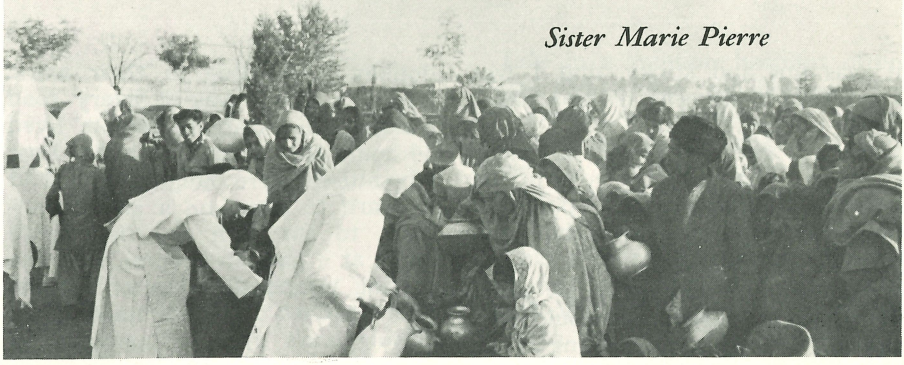
Name .....

Street .....

City ..... *Zone*..... *State* .....

"A SISTER NEEDING TO GIVE . . ."

Sister Marie Pierre



Sister M. Pierre (author) giving out milk, Holy Family Hospital, Rawalpindi, W. Pakistan.

I was walking Kazmi up the stairs to her room last evening. She is an old patient who has been admitted several times. Just to cheer her a little, I jokingly said, "Kazmi, you must love Holy Family; you come here so often." She smiled wanely and replied, "Well, Sister, isn't it nice to have a place you can come and get a little love." She seemed to say it from deep down inside and for a moment, I was so proud to be a part of the hospital. It seemed to me that the rather elusive 'something' which I had conceived my vocation to mean had come to life and was walking down the hall with me.

Here was someone for whom I could be a Medical Mission Sister to the full. Together, we made a team. She was sick and needed skilled treatment; she was frightened and poor and needed sympathetic understanding; she belonged to those many who know not Christ and need contact to come to His Truth. Kazmi was sent to me; she needed my love and my care. I had been chosen for Kazmi's sake to give of myself generously and joyfully. It did not matter that our skin did not match color, that we spoke a different language, that our backgrounds were worlds apart. Here and now we found a bond that linked us as none other could . . . a woman needing to receive, a Sister needing to give.

A Sister needing to give . . . how strange that sounds. Everyone knows that a Sister has nothing she can call her own, no *thing* she can give. Isn't that what her vow of Poverty entails? I helped Kazmi get settled in her bed. I put her few belongings in the small doolie at her side, I poured her a glass of water from a nearby sirai. This was what I could give, freely and lavishly . . . myself, in service to her. It was the need of my vocation as a Sister and it was a language Kazmi understood. Nothing she had learned from books, nothing ethereal or 'up in the clouds' but something that spoke to her heart, a concrete object she could grasp, a bed with clean sheets, a drink for her thirst, medicine to cure and quiet her. She knew from previous experience that she was in competent hands; she trusted those about her and now she could actually feel that it was good to be with them.

I stayed just a few minutes longer, told her I would ask Miriam to make her well quickly which brought a grateful smile and then turned to go downstairs. In my heart I was singing. I don't know why. It was just good to have made an effort to serve and to have found an appreciative heart. I forgot that

it was hot and sticky, that I was tired, that there was tedious paper work waiting for me. All I knew was that the small bit of me I could give had filled a void in the heart of another woman, a potential member of Christ, and that was enough for me.

Had anyone told me a few years ago that missionary life would consist of just such small trifling items, tied together into a day consecrated from dawn to moonlight to God, I would have frowned and questioned them. Few hair-raising snake stories here, not a single head-hunting cannibal, no long treks through dark, mysterious jungles. Instead, the busy routine of a hospital, the joys and tragic moments that come when life and death are the tools of one's daily trade, the problems of more patients than staff or room allow for. These, set into an environment and culture foreign to one, among a people new and strange to one, with a language difficult and puzzling to one, and worst of all, upon ground, as yet, hard and unrelenting to the seed of Christianity.

For a long time one moves about as a stranger in a strange world, constantly amazed that people and places and patterns of life can be so far removed from one's own familiar way. In the first weeks I saw babies, more like chocolate drops than anything else, riding with seeming ease on their mother's hips, black-eyed, dancing children playing dangerously close to the edge of the flat roofs of their mud houses, women winding in and out of the streets like ghosts covered from head to foot with a long, sheet-like garment that hides their faces from the gaze of strange men, and men themselves, in baggy full pants and long tailed shirts driving a flock of goats through the markets, riding a donkey or cycling to their work. Kipling's 'Kim' was at every road crossing, the 'Arabian Knights' lived 24 hours, the heroes of Khyber Pass adventures were neighbors. I had to learn to sleep on a string mattress, to eat with my fingers, to move at a pace in keeping with the soaring temperature, to accept the East as East. It was a question of closing one's eyes to memories of broad boulevards, super-markets, escalators and Fifth Avenue styles in order to taste to the full the amazing scenes and world of the here and now.

I struggled for a time; the language was not easy to learn; the patients had to become individuals for me, real people with joys and sorrows, fears and ideals like my own; the heat and cold had to temper me. I never saw the poor so poor, the sick so sick, the downcast so in need of comfort. It was a time of adjustment, of orientation and there were the inevitable growing pains. But eventually a day came . . a day, when I felt I belonged, when I was no longer an outsider looking on but part and parcel of the life around me. I could stop an old patient for a chat, ask about her baby, comment on the heat; I could enquire from an old bearded babba about his aching joints and respect his patriarchal blessing; I could sympathize with a man whose young wife had just died in childbirth, brought too late to be saved.

Each one calls me "Sister"; I call them "my friends." This is the privilege of my vocation—the joy of it. Like Ruth, these people have become my people, these lands, my lands. I left all else behind to make this come true, and in loving and serving them for His sake my vocation is fulfilled abundantly.

all in a days work

Sister M. Joanna

Life in a mission hospital often seems like a wild rush between life and death, but luckily the incongruous steps in, tickles your funny bone and challenges your sense of humor, whether you have one or not?

Take a morning at the admission desk for instance. Never a dull moment! Visitors, salesmen, relatives, patients, start the ball rolling . . . information to give, packages to acknowledge, food tiffins to carry upstairs to patients, birth reports to send out. It's almost like an avalanche. Sister receptionist thinks she is back in New York at Times Square, but Urdu quickly brings her down to earth. Quickly those five sentences she learned the other day for admissions, tumble out. Across the counter, a meek little man is waiting to admit his wife. She needs an operation. He is terribly worried. Sister breezes through the five questions. The more anxious the man gets, the more Urdu Sister spouts, until she has exhausted her whole vocabulary. Finally the monologue comes to a dead end with the calm, polite remark, "Sorry Sister Sahib, I don't understand English!"

So Sister has language problems! The telephone rings. Sister picks up the receiver. Excited sounds. No words. A trembling voice pierces through asking: "What kind of a child, my wife had last night?"— "A baby girl", says Sister. . . . "Can't hear you, what sex is my child?" . . . "You have a daughter," repeats Sister. . . "What species, may I ask?" . . . "Human, I'm quite sure." "Please tell me what gender is the infant? . . . (it clicks: grammar, no, biology yes) "A female child", asserts Sister. Chuckles ring out, peace on the air. "A female, at last after five boys," concludes the father with great gusto, Sister puts

down the receiver determined to learn the King's English next time.

Medical records, charts, statistics, what shall I do first? Here comes a fond father, what will he want? "Please cut my baby's name off the hospital." "But why, he is still so sick." "I must take him home, everytime I leave him, he cries for me.

Another husband: "When will Shanti Devi have her operation? How soon can she go home?" — "My dear sir, who said she needed an operation?" "Oh, I told the doctor myself".

Next on the program is the census. You might think it is easy to track down 150 patients in a building meant for 100. Sister proceeds to go around to each floor and each bed to check if faces correspond to names listed on the register. Sister really likes this. Oh, the beautiful faces and grateful eyes of the Muslim women on the wards. They are so eager to tell her that the Sisters are so kind to them, and that junior in the new born nursery is treated like a prince. Oh, yes, the census . . . Numbers, don't tally. Three new faces in that picture book, the pediatric ward, two little urchins missing. Wait until you get to the newborn nursery. The private rooms now . . . "Salaam Zabaida," Sister beams as she looks toward a patient's bed. No sign of life, no answer! From underneath cushions and blankets, on the relatives bed, emerges Zabaida. Yes, she's the patient, but her mother-in-law is not well this morning, so *she* went for the patient's treatment — Figure that out. . . .

Where is the patient in the other private room? "She went home to feed her COW!" With a fever of 103??? Well, I hope she won't be too sick to come back!

And so the merry-go-round goes on . . . Sickness, pain, suffering, consolation, and joy. They are always on the threshold of the mission hospital. But they make the medical mission apostolate a very humble one, concerned as it is with body and soul. But because it is life itself that is at stake, there is hope and joy and trust. . . It is Christianity in action . . . a language that all understand.

YOUR WILL . . .

can help the Medical Mission Sisters bring health and healing to the sick and suffering of mission lands. The following approved form of bequest may be used:

"I hereby give (devise) and bequeath to the Society of Catholic Medical Missionaries (also known as the Medical Mission Sisters), an institution incorporated under the laws of the State of Maryland, and its successors forever the sum of $_____for its purposes."

If you have already made your will, it is not necessary to make a new one. It is sufficient that a codicil be added, using the above.

NEWS FROM OUR HOUSES

PHILADELPHIA PROFESSION CEREMONY, FIRST AND FINAL VOWS, AUG. 15, 1958

Front row, left to right: Sr. Rose Bernard, Sr. Regina, Marie, Sr. M. Cabrini, Rev. Robert Lawrence, OSA, Rev. Thomas Duffy, CSC, Mother M. Benedict, American Provincial of the Medical Mission Sisters, His Excellency Joseph M. Yuen, Bishop of Chumatien, China, Rev. Cyril Smith, OSA, Sr. M. Norine, Sr. M. Dominic, Sr. M. Marilyn, Sr. Miriam Therese. Back row, left to right: Sr. M. Deborah, Sr. M. Vianney, Sr. M. Roseanne, Sr. M. Raymond, Sr. Maria Goretti, Sr. M. Aidan, Sr. M. Denise and Sr. M. Ellen. Sr. M. Cabrini and Sr. M. Norine made perpetual vows.

FIRST VOWS IN ENGLAND:

Sister M. Mercia Evans
Sister M. Dominica Zuzek

FINAL VOWS IN THE MISSIONS:

Sister M. Charlotte Gusmano, South Shields, England
Sister M. Evelyn Schild, New Delhi, India
Sister M. Nathaniel Reilly, Thuruthipuram, S. India
Sister M. Jutta Hadamek, New Delhi, India
Sister M. Rupert Amon, Mandar, India
Sister M. Patricia Patton, Techiman, Ghana, Africa
Sister M. Maurice Pomes, Caripito, Venezuela, S. America
Sister M. Pius McDermott, Mandar, India
Sister M. Campion Reynolds, Karachi, W. Pakistan
Sister M. Paulette Elking, St. Louis Mo.

GROUND BROKEN FOR NEW NOVITIATE

Reverend Bernard McCaffrey, C.S.C. officiated at the blessing and breaking of ground for the new novitiate building to be constructed on the grounds of the Medical Mission Sisters, 8400 Pine Road. The ceremony which took place on June 15th was a private one with only the Sisters present. Mother Anna Dengel, M.D., Superior General of the Society, turned the first shovel of earth, followed by Mother M. Benedict, Provincial, and other members of the community.

Blessing at the Ground Breaking Ceremony

℣. *Our Help is in the Name of the Lord.*

℟. *Who made heaven and earth.*

LET US PRAY

O God, from Whom everything good takes its origin and receives its steady and full growth, grant, we beseech Thee, that what we are starting to build for the glory of Thy Name, may, by the ever present aid of Thy Fatherly Wisdom, be brought to completion. Through Christ Our Lord.

℟. *Amen.*

WE'VE FINALLY STARTED

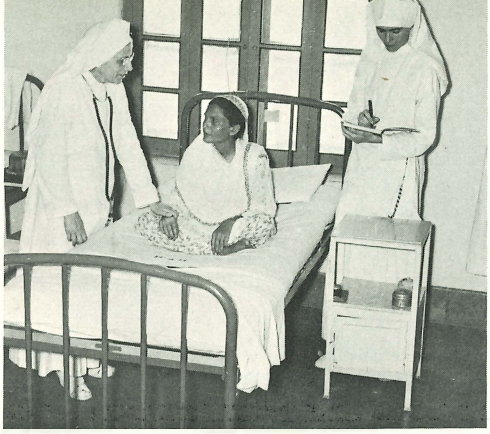
MEDICAL MISSION SISTERS, PHILADELPHIA, PA. (11)

Here is my contribution towards bringing the novitiate building to a completion soon.

Name .....

Address .....

City and State .....



KARACHI, WEST PAKISTAN—Sr. M. Grace, M.D., and Sr. M. Ruth, R.N. with new patient at Holy Family Hospital. Since its beginning in 1948, the hospital has emphasized maternity care.

BHARANANGANAM, KERALA, S. INDIA — Indian Medical Mission Sister with a patient, leaving the Immaculate Heart of Mary Hospital, which is ten years old this month.

BEREKUM, GHANA, WEST AFRICA — At the Tenth anniversary celebration of Holy Family Hospital, Berekum, Sisters, nurses and friends come together.

Medical Mission Sisters are dedicated to the Mother of Christ under the title, Cause of Our Joy

GOLDEN JUBILEE FOR THE CHURCH IN THE UNITED STATES

1908 1958

IT IS ONLY 50 YEARS SINCE PIUS X DECLARED THE CHURCH IN THE U.S. NO LONGER A FOREIGN MISSION.

NOW IT IS OUR TURN TO GIVE THE FAITH TO OTHERS.

SHARE YOUR GIFT OF FAITH

MISSION SUNDAY OCTOBER 19, 1958

SUPPORT THE SOCIETY FOR THE PROPAGATION OF THE FAITH.

+ MISSION SUNDAY BROADCAST LISTEN IN: +

AVE MARIA RADIO HOUR "NUN SURGEON IN THE ORIENT"

A NARRATIVE BASED ON ACTUAL INCIDENTS IN THE LIFE OF ONE OF OUR MEDICAL MISSION SISTER SURGEONS PIONEERING IN A JUNGLE HOSPITAL IN ASIA.